

## NOTICE OF INDEPENDENT REVIEW DECISION

July 23, 2003

RE: MDR Tracking #: M2-03-1383-01  
IRO Certificate #: IRO 4326

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a \_\_\_ physician reviewer who is board certified in pain management and anesthesiology which is the same specialty as the treating physician. The \_\_\_ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient was injured on \_\_\_ when she slipped at work and fell flat on her back, lifting her head to prevent hitting the floor. She has undergone right SI joint injections and physical therapy. An MRI performed 10/24/01 revealed a small disc herniation at L4-5 but no radiculopathies noted.

### Requested Service(s)

30 sessions of outpatient chronic pain multi-disciplinary management services

### Decision

It is determined that the proposed 30 sessions of outpatient chronic pain multi-disciplinary management services are medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

This patient has had pain since an injury on \_\_\_. She has developed psychological traits of chronic pain syndrome (dictation 06/02-Cuellar). She has undergone extensive treatment including medications (NSAIDs and analgesics) and injections without much success. Psychological evaluation shows traits such as poor

coping, sleeping disturbances, anxiety, depression, decreased activity, and high sense of disability due to the pain. Evidence-based approaches to this kind of chronic pain patient show best response from treatment with a multidisciplinary pain program as long as vocation issues are addressed, as clearly stated in the request for this program. The North American Spine Society guidelines recommend a multidisciplinary pain program at this tertiary stage of treatment (*Unremitting low back pain. In: North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists. North American Spine Society (NASS); 2000. 96p).*

The functional capacity evaluation (FCE) from March 2002 shows no symptom exaggeration and negative Waddell Signs and negative inappropriate illness behavior. She also showed consistent effort throughout the evaluation. Therefore, it is determined that the proposed 30 sessions of outpatient chronic pain multi-disciplinary management services are medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 23 <sup>rd</sup> day of July 2003.
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